CVH-171 **CONNECTICUT VALLEY HOSPITAL**
New 5/18 **ADMISSION NURSING ASSESSMENT**

Patient Name: _____

[ ] General Psychiatry Division

MPI# _____ *Print or Addressograph Imprint*

*I. DEMOGRAPHICS

Date of Admission _____ Time _____ am/pm Accompanied by: _____

Type of Commitment: _____ Legal Involvement: (*court date, parole, etc.*): _____

Date of Birth _____ Age _____ Sex: [ ] Male [ ] Female Marital Status: _____ Veteran: [ ]Yes [ ]No

Race: [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] American Indian/Alaskan Native
[ ] Native Hawaiian/Other Pacific Islander [ ] Mixed/Other

Preferred Language Spoken: _____ Other Languages: _____

1. If the patient prefers to speak in a language other than English, does the patient require an interpreter? [ ] Yes [ ] No
2. Can the patient read and understand documents written in English? [ ] Yes [ ] With Assistance [ ] No

*II. REASON FOR HOSPITALIZATION

A. Patient's Statement (why he/she is hospitalized): _____

_____

B. History of Present Illness (factors/stressors necessitating hospitalization): _____

_____

_____

*III. BIOPHYSICAL ASSESSMENT

A. VITAL DATA

Does the patient have an Advance Directive: [ ] Yes [ ] No **(*Also complete CVH-407*)**

Height _____ Weight _____ Blood Pressure _____ Temperature _____

Pulse _____ Respirations _____ Pulse Ox _____ % Room Air

Allergies and/or type of adverse reaction: _____

Date of Last Tetanus (Td) booster or Pertussis (T-dap) Immunization: _____

Date of Last PPD skin test or Quantiferon TB - ELISA (blood test) _____ Results: _____

Primary Care Provider/Clinic: _____

B. EXISTING HEALTH PROBLEMS (*current or history of*):

[ ] Arthritis
[ ] Asthma
[ ] Cancer
[ ] Cardiac Disease
[ ] Constipation
[ ] COPD
[ ] CVA
[ ] Diabetes
[ ] GERD
[ ] Head Trauma
[ ] Hepatitis
  [ ] A
  [ ] B
  [ ] C
[ ] History of Seizures
[ ] HIV/AIDS
[ ] Hypertension
[ ] Liver
[ ] Renal
[ ] Thyroid
[ ] Other: _____

Comments:

C. CURRENT MEDICATION

Complete Admission Medication List and Verification Form (Medication Reconciliation) CVH-581a and Continuation Form CVH-581b.

*To be obtained at time of admission

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

***C. Assessment of Pain: [ ] No report of pain at this time** **If the patient reports pain, complete as indicated.**

Current or History of Pain (*Please Specify*): _____

FLACC Pain Scale: **If the patient is non-verbal and unable to provide information about pain, Please complete the FLACC Scale (Face, Legs, Activity, Cry and Consolability to assess pain.**

Severity: ☐(*1-10*): _____ *OR*

Location: _____ ☐ FLACC Score: _____ **Onset**: _____

Duration: ☐ Acute Pain (*Few seconds to less than 6 months*) ☐ Chronic Pain (*Greater than 6 months*)

Type of Pain (*Circle all that apply*):	**Quality of Pain:** (*Circle all that apply*):
• Cutaneous (*Sensation*)	• Sharp
• Somatic (*Tendons, Ligaments, Bones, Blood Vessels, Nerves*)	• Dull
• Visceral (*Organs*)	• Diffuse
• Referred	• Shifting
• Neuropathic (*Functional pain*)	• Burning

Aggravating Factors (*Circumstances which cause pain to return or escalate*): _____

Alleviating Factors (*Techniques or circumstances that reduce or relieve the pain*): _____

Effect on Level of Functioning (*Sleep, Changes in Mood, Appetite, Work, Exercise, ADL's, Relations*): _____

Current Treatments	**Effectiveness** (*Relief, Some Benefit, Not Effective):*
• Drug Therapy (*please specify*): _____	_____
• Acupuncture • Biofeedback	_____
• Relaxation/Meditation/Imagery • Heat/Cold	_____
• Other: _____	_____

Does pain appear to be associated with substance withdrawal?: ☐ Yes ☐ No ☐ N/A

Does pain appear to be associated with a co-occurring medical issue?: ☐ Yes ☐ No ☐ N/A

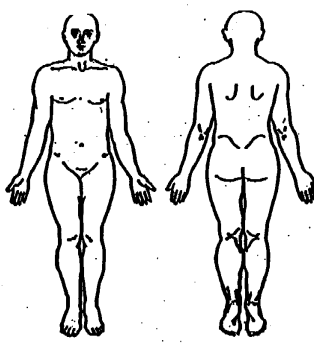
If yes, please specify and include nursing specific educational interventions in the Initial Nursing Plan of Care.

Any identified pain issues refer to the ACS Clinician and Psychiatrist.

E. OBSERVATIONS – Identifying Marks/Injuries *Check all applicable observations and indicate on figure location:*

[ ] None Observed	[ ] Rashes	Comments:
[ ] Bruises	[ ] Scars	
[ ] Cuts	[ ] Sutures	
[ ] Decubiti	[ ] Tattoos	
[ ] Discolorations	[ ] Track Marks	
[ ] Open Wounds	[ ] Other: _____	
[ ] Piercings *(note object & location)*	_____	

FRONT BACK



*To be obtained at time of admission

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

F. Nutritional/Metabolic (*Check all that apply)*

[ ] Weight loss (*last 3 mos. if known*)
approx. amount: _____
[ ] Weight gain (*last 3 mos. if known*)
approx. amount: _____
[ ] Appearance:
[ ] underweight
[ ] over weight
[ ] malnourished
[ ] Other: _____

[ ] Eating habits:
[ ] loss of appetite
[ ] slow eater
[ ] fast eater
[ ] refusal to eat
[ ] Fluid Intake:
[ ] poor
[ ] adequate
[ ] excessive

Cultural food preferences: _____

[ ] No Nutritional/Metabolic impairments noted

G. Nutrition Screen (*Check all that apply)*

Are any of the following conditions known?

[ ] diabetes
[ ] renal disease
[ ] cancer
[ ] AIDS or HIV
[ ] eating disorder
[ ] tube feeding
[ ] on a special diet or NPO
[ ] experiencing slow healing wounds

Is the patient?

[ ] pregnant or breastfeeding
[ ] taking MAOI within the last 2 weeks
[ ] experiencing symptoms of anorexia or bulimia
[ ] receiving dialysis
[ ] having chewing or swallowing difficulties
[ ] taking any nutritional supplements or other herbal remedies
[ ] food allergies: _____

[ ] No positive results noted in above Nutritional Screen

Any positive response/impairment noted in the Nutritional/Metabolic or Nutritional Screen a Nutritional Consult is ordered: Notify ACS Clinician During Business Hours and the On Call MD for 2nd and 3rd shifts, weekends and holidays.

Notified by: _____ Date and Time: _____

and **Notify Dietary Department (leave voice mail)**

Message left by: _____ Date and Time: _____

H. INFECTIOUS DISEASE SCREEN

Complete Infectious Disease Screen CVH-628

I. Prosthetic Devices		**Comments**
[ ] Artificial limb(s) [ ] Contact lenses [ ] Dentures [ ] full [ ] partial [ ] Glasses	[ ] Hearing aid [ ] None [ ] Ostomy devices [ ] Pacemaker [ ] Other: _____	
J. Activities of Daily Living 1. **Grooming/Personal** *Indicate* **I = Independent or A = Assisted** • Bathing _____ • Dressing _____ • Eating _____ • Hair Care _____	• Hygiene _____ • Shaving _____ • Showering _____ • Toileting _____ • Other: _____	
2. **Mobility/Ambulation** [ ] Full [ ] Partial [ ] Non-ambulatory	*Indicate:* **I = Independent or A = Assisted** • Cane _____ • Crutches _____ • Prostheses _____ • Transfer _____ • Walker _____ • Wheelchair _____	

K. Fall Risk

Complete Fall Risk Screening CVH-574

*To be obtained at time of admission

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

IV. INTERPERSONAL CONSIDERATIONS

A. Relations

1. Who are the important people in your life? _____
2. Who do you want involved in your treatment plan meeting? _____
3. Describe how easy or difficult it is for you to get along with others: _____

B. Self Concept

1. Describe what you like about yourself: _____
2. Describe what you would like to change about yourself or traits you'd like to work on: _____
3. Are there hobbies or interests which give you pleasure? _____

C. Sexuality

1. Within the last month have you been sexually active? [ ] No [ ] Yes
2. What is your sexual preference? _____
3. Do you use precautions? [ ] No [ ] Yes Describe: _____
4. Have you ever gotten into trouble because of your sexual behavior? [ ] No [ ] Yes Describe: _____

D. Spiritual

1. Do you currently practice any religion? [ ] No [ ] Yes Describe: _____
2. How will your spiritual beliefs/practices be affected while in the hospital? _____

E. Cultural

1. Do you have any specific beliefs regarding the emotional/mental or physical distress you are experiencing?
   [ ] No [ ] Yes Describe: _____
2. Do you or your family have any remedies which you use to address your health problems?
   [ ] No [ ] Yes Describe: _____
3. Are there any cultural or family practices you would like us to know about while you are in the hospital?
   [ ] No [ ] Yes Describe: _____

*V. MENTAL HEALTH ASSESSMENT (*Check all that apply*)

Appearance	Affect/Mood	Thought Content (*Describe*)	Thought Process
[ ] Neat, clean, appropriate [ ] Disheveled [ ] Dirty skin, hair, nails & clothing [ ] Other: _____	[ ] Appropriate [ ] Anxious [ ] Cheerful [ ] Dysphoric [ ] Euphoric [ ] Flat [ ] Labile [ ] Other: _____	[ ] No deficits noted [ ] Delusional [ ] Obsessive [ ] Phobic [ ] Suspicious [ ] Other: _____	[ ] No deficits noted [ ] Blocking [ ] Circumstantial [ ] Looseness of associations [ ] Racing [ ] Tangential [ ] Other: _____

Orientation	Perceptions	Memory	Motor Behavior	Speech
[ ] Oriented [ ] Disoriented (*time, place, person*) [ ] Confused	[ ] Reality based [ ] Hallucinations [ ] Illusions	[ ] Recent memory in tact [ ] Remote memory intact [ ] Deficits in recent memory [ ] Unable to assess due to other impairments	[ ] No deficits noted [ ] Agitated [ ] Pacing [ ] Psychomotor retardation [ ] Repetitive movements	[ ] No impairments noted [ ] Monosyllabic [ ] Mute [ ] Pressured [ ] Rapid [ ] Slow [ ] Slurred [ ] Stuttering [ ] Other: _____

*To be obtained at time of admission

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

*VI. SUBSTANCE ABUSE HISTORY/CURRENT USE

[ ] No history or evidence present at this time. (*Sections A – C do not apply*)

A. SUBSTANCE ABUSE/CURRENT USE PATTERNS – WITHDRAWAL POTENTIAL

Substance	Amount, Frequency, Route	Duration of Use	Use During the Past 12 Months Y/N	Date/Time of Last Intake	Comments
Check those that apply: [ ] Alcohol [ ] Heroin [ ] Cocaine [ ] Marijuana [ ] Amphetamines [ ] Nicotine [ ] Others (*list*):					

B. Has the patient used any prescription medication, over the counter medications, inhalants or herbal preparations outside the prescribed and/or recommended dosage in the past 12 months?
[ ] No [ ] Yes – If yes, please list: _____

_____

Last Blood Alcohol Level _____ Date _____ Time _____

C. Complications [ ] No evidence at this time

	Date of (Last) Occurrence	Comments
[ ] Blackouts		
[ ] D.T.'s		
[ ] Withdrawal Seizures		
[ ] Paranoia/Psychosis		
[ ] Depressed Mood		
[ ] Other:		

D. Identify the patient's strengths related to abstinence/sobriety (*Check all that apply*)

STRENGTHS

[ ] Familiar with self-help/12 Steps
[ ] Voluntary Admission
[ ] Requesting Treatment
[ ] Has Sponsor
[ ] Past/Recent Period(s) of Sobriety
[ ] Family Support
[ ] Employer Support
[ ] Cognitively Sound
[ ] Desires Rehab Program
[ ] Motivation to Succeed in Treatment
[ ] Other: _____

*VII. RISK ASSESSMENT

A. SELF-HARM AND SUICIDE RISK (*Check the appropriate answer (Y/N) and comment on patients' answers or record patients' response to specific questions.)*

		COMMENTS/PATIENT RESPONSE
1	How does the future look to you?	
2	What things in your life make you want to go on living?	
3	Whom do you rely on during difficult times?	

*To be obtained at time of admission

		COMMENTS/PATIENT RESPONSE
4	Has treatment been effective for you in the past? [ ] Yes [ ] No [ ] N/A	
5	Are there things that you've been feeling guilty about or blaming yourself for? [ ] Yes [ ] No	
6	Did you ever wish you could go to sleep and just not wake up? [ ] Yes [ ] No	
7	Have you ever felt that life is not worth living? [ ] Yes [ ] No	
8	Do you consider yourself an impulsive person? [ ] Yes [ ] No Why or Why Not?	
9	When people are feeling extremely upset, they sometimes have thoughts of wanting to harm themselves. Have you had any thoughts of wanting to harm/hurt yourself? [ ] Yes [ ] No ***If no, proceed to # 12***	
10	If you begin to have thoughts of harming yourself what would you do?	
11	Have you ever acted on these thoughts? [ ] Yes [ ] No *If yes*, please describe:	
12	Have there been times when voices told you to hurt or kill yourself? [ ] Yes [ ] No	
13	Have you ever had thoughts of wanting to kill yourself? [ ] Yes [ ] No ***If no, proceed to # 27***	
14	Can you tell me about the first time you ever thought about suicide?	
	a. What triggered your thinking about suicide?	
	b. Why did you think suicide was the best option at that time?	
	c. Did you want to die? [ ] Yes [ ] No	
	d. Please tell me exactly what you did.	
	e. Were you injured by the suicide attempt? [ ] Yes [ ] No	
	f. Did you receive medical care? [ ] Yes [ ] No	
	g. Did you take steps to prevent your discovery or rescue? [ ] Yes [ ] No	
	h. How do you feel about surviving?	
	i. Did you learn anything helpful about yourself or others? [ ] Yes [ ] No	
15	Have there been other times in your life when you tried to kill yourself? [ ] Yes [ ] No *If yes*, please describe when, where, why and how.	
16	Have you thought about or attempted suicide in the past year? [ ] Yes [ ] No	
17	Have you thought about or attempted suicide in the past month? [ ] Yes [ ] No	
18	How often do you think about killing yourself? (*Check one*) **Frequency:** [ ] Never [ ] Rarely [ ] Sometimes [ ] Frequently [ ] Daily	
19	When you have these thoughts, how intense or severe are they? (*Circle one*) **Intensity:** Mild 1 2 3 4 5 6 7 8 9 10 Severe	

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

		COMMENTS/PATIENT RESPONSE
20	Have you thought about when you would kill yourself? [ ] Yes [ ] No	
21	Have you thought about where you would kill yourself? [ ] Yes [ ] No	
22	Have you thought about how? [ ] Yes [ ] No	
23	Do you have access to the means to end your life? [ ] Yes [ ] No *If yes*, please describe:	
24	Have you made any particular preparations? [ ] Yes [ ] No	
25	Have you rehearsed your suicide in any way? [ ] Yes [ ] No	
26	Why do you want to die?	
27	Has anyone in your family attempted suicide? [ ] No [ ] Yes *If yes*, date: _____ (*month/year*) Please identify who, when and circumstances:	

28	Self Harm and Suicide Risk History:	**EVER**	**Past 6 Months**
	• Indication of Self Harm	[ ] Yes [ ] No	[ ] Yes [ ] No
	• Self Mutilating Behaviors	[ ] Yes [ ] No	[ ] Yes [ ] No
	• Suicidal Ideation	[ ] Yes [ ] No	[ ] Yes [ ] No
	• Suicidal Intent	[ ] Yes [ ] No [ ] Unknown	[ ] Yes [ ] No [ ] Unknown
	• Suicide Plan	[ ] Yes [ ] No [ ] Unknown	[ ] Yes [ ] No [ ] Unknown
	• Single Attempt	[ ] Yes [ ] No	[ ] Yes [ ] No
	• Multiple Attempts	[ ] Yes [ ] No	[ ] Yes [ ] No
29	Patient reluctant to discuss information regarding history and may be withholding information. [ ] Yes [ ] No		

Immediately notify the MD if there are any YES responses or new information is obtained regarding the patient's suicidal potential which was not elicited during the MD assessment.

MD Contacted: [ ] No
[ ] Yes: _____ _____ _____AM/PM
Physician Name Date Time

Contacted by: _____ _____
RN Signature Print Name

B. AWOL RISK (*Check all that apply)*

[ ] No evidence at this time
[ ] History of AWOL attempts
[ ] Expressed desire to go AWOL
[ ] Denies need for hospitalization

Comments

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

C. VIOLENCE RISK (*Check all that apply*)

[ ] No current evidence or history of violence risk

[ ] Fire Setting
[ ] Ever
[ ] Past 6 months (*Dates*) _____

[ ] Abuse of Animals
[ ] Ever
[ ] Past 6 months (*Dates*) _____

[ ] Violence (Property or Person)
[ ] Ever
[ ] Past 6 months (*Dates*) _____

[ ] Homicidal Ideation
[ ] Ever
[ ] Past 6 months (*Dates*) _____

Describe Contributing Factors – Consider precipitants to anger, substance use, delusions of persecution, cognitive impairment, history of seizure.

_____

Describe Motive, Intent, Access To Weapons: _____

D. ASSESSMENT OF VICTIMIZATION

Introduction: Many of our patients have had upsetting experiences at some time in their lives. In order to give you the best care, we think it is important to find out if you have ever had something very upsetting happen to you. I am going to ask you a few questions about things that you may have seen or experienced at some time in your life. I will only ask a few questions and you can answer just "yes" or "no" now. Later, someone else will talk to you about any upsetting experiences you have had. You don't have to answer any questions you don't want to, and we can stop this part of the interview any time you would like.

1. At any time in your life, have you seen someone seriously injured? [ ] Yes [ ] No
2. At any time in your life, have you witnessed a physical or sexual assault against a family member, friend, or other significant person? [ ] Yes [ ] No
3. At any time in your life, has anyone physically hurt you or threatened to physically hurt you? [ ] Yes [ ] No
4. When you were a child, did anyone touch in a sexual way? Yes [ ] No [ ]
5. At any time in your life, has anyone touched you sexually or forced you to have sex when you did not want to? [ ] Yes [ ] No

* *If yes to any of the above questions, ask the following*:

6. Have any of these things happened to you in the last 12 months? [ ] Yes [ ] No
7. Since this happened to you, have you:
   - been more worried or fearful [ ] Yes [ ] No
   - experienced unpleasant memories [ ] Yes [ ] No
   - tried to avoid certain thoughts or situations [ ] Yes [ ] No
   - had difficulty sleeping? [ ] Yes [ ] No

* *If yes to any part of question #7, continue to #8*

8. Have you found anything to be helpful when you have these experiences? [ ] No [ ] Yes – If yes, describe: _____

9. Does the patient appear vulnerable or at risk of victimization while hospitalized? [ ] No [ ] Yes – If yes, describe: _____

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

E. PAST HISTORY OF SECLUSION & RESTRAINT

1. What are some of the things that make you angry? _____

2. How do you generally respond or behave when you get angry? _____

3. Have you ever been physically restrained or placed in seclusion? [ ] No [ ] Yes – Date of last incident: _____

   Describe when, where, what happened, and reaction to restraint: _____

   _____

   _____

4. The CVH Seclusion and Restraint policy was reviewed with the patient. [ ] Yes [ ] No Reason: _____
   If restraint or seclusion becomes necessary, who would you like staff to notify?

   Contact Name _____ Phone Number: _____

   Patient has signed a Release of Information to notify person(s) designated [ ] Yes [ ] No - If no, inform Social Worker

   Social Worker name: _____ Date and Time of Notification: _____

5. Is there a pre-existing medical condition or disability that places the patient at risk should seclusion/restraint be utilized?

   [ ] No [ ] Yes, If yes please describe: _____

   _____

6. Is there history of sexual abuse that places the patient at greater psychological risk during seclusion/restraint?

   [ ] No [ ] Yes, If yes please describe: _____

   _____

F. PERSONAL PREFERENCES

1. What helps when you are not feeling well? (*Check all that apply*)

[ ] Lying down with a cold face cloth	[ ] Wrapping up in a blanket	[ ] Deep breathing
[ ] Additional/extra medication	[ ] A warm or cool drink	[ ] Eating something
[ ] Taking a shower or bath	[ ] Reading	[ ] Writing in a diary/journal/letter
[ ] Exercise	[ ] Drawing	[ ] Playing a game
[ ] Sitting by the nurses station	[ ] Watching TV	[ ] Talking to staff
[ ] Calling your therapist	[ ] Talking with another patient	[ ] Talking with chaplain
[ ] Calling a friend or family	[ ] Pacing the halls	[ ] Listening to music
[ ] Going for a walk	[ ] Other, specify below	

   Elaborate on above choices as needed: _____

   _____

   What are some things that make it more difficult for you when you are already upset? (*Check all that apply*)

[ ] Being touched	[ ] Bedroom door being opened	[ ] People staring at me
[ ] Not having input/choices	[ ] Not being able to express my opinion	[ ] Being criticized
[ ] Being isolated/alone	[ ] Lack of staff availability/attention	[ ] Boredom/lack of activities
[ ] Seeing people in uniform	[ ] Loud noise	[ ] Yelling
[ ] Noise in general	[ ] Particular time of day	[ ] Time of year

   Elaborate on above choices as needed: _____

   _____

VIII. HEALTH TEACHING NEEDS (*Check all that apply*)

A. Patient's Preferred Method of Learning

[ ] One on One Teaching [ ] Group Discussion
[ ] Written Information [ ] Other: _____

B. Barriers to Learning

[ ] None [ ] Speech [ ] Other: _____
[ ] Developmental Disabilities [ ] Hearing

C. Nursing Educational Needs

[ ] Symptom Recognition [ ] Medical Condition [ ] Interpersonal Relations [ ] Psychiatric Illness/Treatment
[ ] Symptom Management [ ] Medication [ ] Pain [ ] Self Care [ ] Other: _____

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

IX. PATIENT STRENGTHS (*Check all that apply*)

[ ] Ability to verbalize needs
[ ] Ability to articulate clearly
[ ] Motivated for treatment
[ ] Ability to collaborate
[ ] Assertive
[ ] Positive Attitude
[ ] Goal Directed
[ ] Values Health and Wellness
[ ] Knowledge regarding own self-care issues
[ ] Uses support system
[ ] Ability to make relationships
[ ] Has Hobbies - Describe: _____
[ ] Identifies Interests – Describe: _____
[ ] Vocational Interests, Describe: _____
[ ] Other: _____

Coping Style/Preferences to decrease stress and avoid conflict. _____

Signatures:

Signature of Initial Assessing Registered Nurse	Date	Time	Print Name
Signature of Subsequent Assessing Registered Nurse	Date	Time	Print Name

*To be obtained at time of admission

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

*X. SUMMARY OF FINDINGS AND NURSING INITIAL PLAN OF CARE

This page may be omitted if a computerized Nursing Plan of Care is completed at the time of admission & filed in the Treatment Plan Section of the Medical Record.
Check box and sign below if a computerized Nursing Plan of Care has been completed.

A. Nursing Care Needs/Problems and any Pain issues will be addressed by Nursing Staff immediately and throughout the first seven (7) days of hospitalization [prior to the development of the Initial Master Treatment Plan].
Prior to Day 7, indicate the status of the problems identified below using the following Key. **Resolved Active Revised Deferred Cancelled**

Nursing Care Needs/Problems	Intervention(s) and Target Date	Assigned Nursing Staff	Status
Psychiatric/Substance Abuse			
Pain			
Medical			
Pain			
Psychosocial			

☐ **A computerized INITIAL NURSING PLAN OF CARE was completed at the time of admission and is filed in the Treatment Plan Section of the Medical Record.**

_____ _____ _____AM/PM _____
Signature of Initial Assessing Registered Nurse Date Time Print Name

B. Nursing Care Needs/Problems and any Pain issues to be referred to the Treatment Team for integration into the Initial Master Treatment Plan (prior to day 7). All unresolved problems listed above to be carried forward to the Initial Master Treatment Plan.

Additional Nursing Care Needs/Problems	Intervention(s) and Target Date	Assigned Nursing Staff

_____ _____ _____ _____ _____ _____
Signature of Subsequent Assessing Registered Nurse Date Time Signature of Subsequent Assessing Registered Nurse Date Time

Print Name: _____ Print Name: _____

*To be obtained at time of admission